January 22, 2014

VIA ELECTRONIC SUBMISSION

Subject: Comments on Medicaid 1115 Draft Application

To Whom It May Concern:

On behalf of the Center for Health Law and Policy Innovation (CHLPI) of Harvard Law School, we appreciate the opportunity to offer comments on the State of Illinois Section 1115 *Path to Transformation* draft waiver application. CHLPI advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, particularly low-income people living with chronic illnesses and disabilities. Our comments focus on the draft application's proposals for community health workers and supportive housing.

We support the waiver's overarching goal of addressing the multiple causes of poor health—especially the social determinants of health—for individuals living in poverty. Achieving this requires states to take a more integrated approach to the delivery of health care, including acknowledging the role played by factors such as community health workers and supportive housing. In support of the state's efforts to become a national leader in Medicaid reform, we respectfully urge consideration of the following recommendations:

Pathway 3 (Workforce): Community Health Worker Training Considerations

We commend the state for including community health workers (CHWs) in the *Path to Transformation* waiver. Evidence strongly suggests that CHWs can improve health outcomes and reduce health disparities, especially when integrated into care teams as proposed in the waiver application. To maximize the benefits of greater CHW involvement in the Medicaid program, we have three recommendations regarding CHW training programs.

First, we urge the state to consider sites outside of colleges where training can be delivered. While community colleges are an excellent location for many people to receive both general

education and vocational training, they may not be accessible for all prospective CHWs. Some schools are within a reasonable distance from the communities from which the state would seek to recruit CHWs, while others may be located at quite a distance. Without easy transportation to more suburban or rural campuses, prospective CHWs are unlikely to sign up for and regularly attend courses. At the same time, several organizations in Illinois have already demonstrated capacity to train CHWs and have functioning programs today. The state should leverage these existing resources by permitting community organizations, including but not limited to healthcare services organizations, to serve as training sites. Adding more options to a training system would take nothing from what will surely be a robust community college program.

Second, we urge the state to make training materials and courses available in common non-English languages. As the draft application notes, CHWs are members of the communities they serve, which include communities where English is not the predominant language spoken. Many prospective CHWs may not have sufficient proficiency in English to succeed in an English-only academic setting, even though they may have a strong capacity to perform CHW tasks, including oral communication with English-speaking physicians and nurses. Some CHWs may also work with health centers where the medical staff is bilingual, in which case strong English proficiency may not be necessary for CHWs to serve as liaisons between patients and medical staff. If Illinois is to maximize the benefits of integrating CHWs into care teams, it cannot systematically exclude potentially hundreds of CHWs who could connect to vulnerable limited-English-proficient communities.

Third, we strongly encourage Illinois to establish CHW training standards rather than developing a mandatory single curriculum. We understand from the draft application that the state intends to develop a curriculum in cooperation with the community colleges. We assume

that the state will collaborate with CHW professional organizations and organizations that currently provide CHW training in developing this curriculum, and we support its creation—particularly if it is made available to non-community college organizations for their use as well. However, one size will not fit all. Language and cultural differences, for example, mean that a single mandatory curriculum would probably fail to meet the needs of all, or even most, prospective CHWs and the communities they serve. For this reason, we encourage Illinois to develop standards, or criteria, that all curricula must meet in order to be accredited to certify CHWs.

We have conducted a survey of state CHW provisions enacted through statute and regulation across the country. As of December 2012, fifteen states and Washington, D.C. had at least one provision relating to CHWs. Of these, none had created a single mandatory curriculum. Instead, Ohio, Oregon, and Texas have each developed minimum curriculum standards. Organizations that conduct training in each state create their own curricula that must conform to state standards.[1] These states vary in the level of detail they provide in their minimum standards, and their approaches may be helpful in considering standards that will meet the needs of Illinois Medicaid. In addition, Massachusetts is in the process of crafting standards, having recently established a board of certification charged with setting standards for training programs.

Pathway 4 (Home and Community Based Infrastructure, Choice, and Coordination):

One of the most critical social determinants affecting the health of those individuals living in poverty is housing stability. Research increasingly supports the claim that the provision of supportive housing to impoverished individuals with complex health needs lowers overall health care costs and improves health outcomes. In fact, the provision of supportive housing to such

[1] Ohio's regulations for CHW training programs may be found at Ohio Administrative Code § 4723-26-13. Oregon's regulations may be found at Oregon Administrative Rules Chapter 410 § 180-0370. Texas's regulations are located at Texas Administrative Code Title 25 § 146.8.

individuals has been shown to be as cost-effective as many other widely accepted public health interventions.[2]

1) **Revise the proposal concerning supportive housing to provide more explicit details on the incentive pool funding mechanism.**

We commend and support the state for recognizing the value of supportive housing as part of its Medicaid reform efforts. However, we urge the state to provide further clarification on the proposed funding mechanism for supportive housing and related services. It is our understanding that the state is proposing to create a funding pool which would allow behavioral health providers whose patients are stably housed to receive incentive payments, which could then be used to pay for transitional rental assistance or for making capital investments in housing for patients. Based on the draft language, the source of these pool-funding dollars is not clear. It would be helpful to all stakeholders for the state to be more explicit about this proposed funding mechanism for supportive housing and related services.

2) **Ensure the provision of funding for housing and related support services through the creation of a direct source of state funding independent of the incentive pool.**

We support the idea of using an incentive pool to fund capital investments, but we urge that the waiver include a non-incentive based, direct source of state funding for the service work associated with the completion of SSI Outreach, Access, and Recovery (SOAR) applications and for the provision of non-federally matchable, transition rental assistance subsidies.[3] The draft language indicates that "housing and related supports" will not appear in the state's Medicaid plan, but instead on a list of "non-State Plan services (known as "flexible services")" (p.41). Also, Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs)

[2] For example, see Holtgrave, David. *Case Study: Housing and HIV* [PowerPoint slides]. Retrieved from 2010 HIV Research Catalyst Forum website: www.hivresearchcatalystforum.org/files/user_1/SYP1Holtgrave.ppt.

[3] Under this suggestion, the draft waiver application's proposed incentive pool would still be used to support capital investments. The completion of SOAR applications and rental subsidies for transitional rental assistance would be funded with our proposed direct payment pool.

are only contractually being asked to "consider" these flexible services such as "housing and related supports" (p.41). The effect of this proposal is that MCOs and MCCNs would be left to pay upfront for supportive housing and related services from their own funds, which could discourage broad MCO/MCCN efforts to partner with supportive housing providers.

A better alternative would be the creation of a pool, funded by the savings generated by state Medicaid dollars, which could provide upfront funding for MCOs/MCCNs to use in paying for SOAR application work and rental subsidies for their qualifying enrollees. Incentives alone are not likely to bring about the desired cost savings and health outcome improvements. The state's commitment to serving populations in need should be reflected in the provision of direct, upfront resources that will ensure cost coverage for supportive housing and related services. While the draft application references individuals with behavioral health issues, we believe that state-funded supportive housing should also be available to people living with complex chronic physical illnesses.

Thank you for your consideration of our recommendations. The *Path to Transformation* waiver represents an important step forward in the use of Medicaid to fund an integrated health care delivery system. Should you have any further questions, please contact Robert Greenwald, Director, Center for Health Law and Policy Innovation of Harvard Law School, at rgreenwa@law.harvard.edu.

Respectfully Submitted,

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